



APPLICATION

HOPE 4 MOBILITY (H4M) FINANCIAL ASSISTANCE
FOR SPECIAL NEEDS EQUIPMENT, PRODUCTS & SERVICES (EP&S) FUND

Hope 4 Mobility, Inc., 4138 Bluff Harbor Way, Wellington, FL 33449, (561) 319-1296

Date: _____

NOTE: If selected, Hope 4 Mobility (H4M) will provide up to a maximum of \$500 towards the purchase of equipment, products & services (EP&S) paid directly to vendor.

Please complete, scan & email application to Hope 4 Mobility, Inc. (info@Hope4Mobility.org)

Name of Applicant: _____ Age: ____ Sex: ____ Date of Birth: _____

Disability and/or diagnosis: _____

Parent(s)/Guardian Name: _____

Address: _____ Zip: _____

Phone: _____ Email address: _____

(If Organization) Name: _____ Contact Person: _____

What is the Equipment, Product or Service (EPS) you are requesting?: _____

Amount requested from Hope 4 Mobility (H4M) for equipment, product or service? (Not to exceed \$500):

How did you hear about us (H4M)?: _____

Complete this section to substantiate & explain what your need is for equipment, product or service.

1. Describe the need (equipment, product or service (EP&S) requested): _____

2. Describe how this equipment, product or service will assist the child or organization: _____



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Name of Applicant: _____

3. Who identified the need for this type EP&S?: _____

4. Approximately how long will the EP&S be used? _____

5. Is the child eligible for: Will agency pay for the equipment requested?

Private Insurance	YES	NO	YES	NO
Medicaid	YES	NO	YES	NO
Children's Medical Services	YES	NO	YES	NO
APD (Agency for Persons with Disabilities)/Developmental Services	YES	NO	YES	NO
Other: _____	YES	NO	YES	NO

If answering yes to any of the above, but funding is not provided by that agency, please explain below.
NOTE: A letter of denial from the declining agency (e.g. Medicaid, insurer) must be submitted for most items. _____

6. For the item requested, attach a price quote from each vendor/manufacture. **Two (2) price quotes** are required, except for items requiring custom measurements, such as wheelchairs. If less than the required number of price quotes are available, explain and document vendors approached (see Guidelines for exceptions).

<u>Vendor/manufacture Name</u>	<u>Price Quote</u>	<u>Shipping Cost</u>	<u>Total Cost</u>
1. _____	\$ _____	\$ _____	\$ _____
2. _____	\$ _____	\$ _____	\$ _____

Total cost of the equipment, products or service requested, including warranty: \$ _____

Amount to be paid by the family (subtract from total): \$ - _____

(Note: It is suggested that families contribute to the cost, at least minimally)



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Name of Applicant: _____

Amount to be paid by civic, religious, community, organizations, or individuals
(List and subtract from total). \$ - _____

Balance (H4M Maximum Funding is \$500): \$ _____

NOTE: Hope 4 Mobility Special Needs Equipment, Products & Service Assistance Funds are paid directly to vendor.

7. Please attach the following items to this application form:

- If a nonprofit agency, attach a copy of the agency’s 501 C (3) status letter from the IRS, Certificate of Insurance and nonprofit corporation status report from the state of Florida.
- Two (2) vendor/manufacture written estimates of the cost of the **EP&S** for requests, except for custom items such as wheelchairs or EP&S available through a sole provider (please give details).
- The appropriate documentation (e.g. letter of medical necessity, etc.) from a licensed/certified provider who is knowledgeable of the child’s condition if applicable.
- Medicaid or insurance denial letter, where required.

I understand that approval of this request rests with the Special Needs EP&S Fund Committee and that all follow-up Questionnaires & Surveys must be completed. Also, for lawful purpose of publicity, illustration, advertising, and Web content, I consent to allow H4M to use name and photos of my child/organization utilizing the equipment, products or services.

By signing the application, the sponsoring public service agency, organization and/or the applicant’s family declares that the family or organization is in need, has no other means to obtain the equipment, product or service and will authorize release of any information to substantiate the request if necessary.

The applicant (family or organization) agree not to hold Hope 4 Mobility liable for any defects, repairs, malfunctions or injury due to use of the EP&S provided through this fund.

Signature of Authorized Agency Representative

Date

Signature of Parent or Guardian

Date

Email To: Info@Hope4Mobility.org

Or

Mail To: Hope 4 Mobility, Inc., 4138 Bluff Harbor Way, Wellington, FL 33449